Annual Report 2016

Ensuring Program Integrity in Virginia's Medicaid and FAMIS Programs

COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

CINDY B. JONES
DIRECTOR

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SUITE 1300
600 EAST BROAD STREET
(804) 786- 7933
(800) 343-0634 (TDD)
www.dmas.virginia.gov

Dear Fellow Virginians:

I am pleased to present the Virginia Medicaid Program Integrity Annual Report for State Fiscal Year (SFY) 2016. Virginia Medicaid program integrity efforts are not limited to a single division within the Department of Medical Assistance Services (DMAS), but involve the entire agency and coordination with a variety of stakeholders. This report is a reflection of those combined efforts.

 DMAS upholds the highest standards of program integrity as the agency is entrusted with the responsibility of ensuring the Virginia Medicaid Program is equipped to combat external fraud, waste and abuse. Only a small percentage of Medicaid providers and recipients engage in program integrity violations. Unfortunately, these actions affect everyone including the recipients of care, the taxpayers who pay for it, and the providers who bill appropriately for quality care. Each dollar lost to fraud is one less dollar available for someone in need.

Over the course of SFY 2016, the agency, both proactively and retrospectively, uncovered or prevented over $156.5 million in improper payments. In addition, we referred over 100 providers to the Office of the Attorney General's Medicaid Fraud Control Unit (MFCU) for further investigation of potential criminal activity. Finally, the agency has continued to work with our managed care partners to enhance program integrity within their organizations as well as within the Virginia Medicaid program as a whole.

This report will provide key statistical information on estimated savings and audit outcomes and highlight broader initiatives to enhance program integrity. I believe you will find this report meaningful and hope you gain insight into the agency's program integrity endeavors of 2016.

Sincerely,

Cindy B. Jones, Director
Virginia Department of Medical Assistance Services

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Year in Review

During SFY 2016, program integrity activities uncovered and/or prevented $156.5 million in improper expenditures in the Virginia Medicaid program. The chart below provides a snapshot of program integrity savings in SFY 2016. A substantial portion of PI savings came from cost avoidance due to the service authorization process, which denies medically unnecessary service requests. To mitigate inappropriate claims that are not identified through prepayment processes, DMAS conducts a variety of post-payment activities, such as medical record reviews, to identify misspent funds. As a result, $23.9 million in identified recoveries is attributable to post-payment audits of providers and recipients conducted by Program Integrity Division staff and contractors. In addition almost $1million in restitution to the Medicaid program was ordered as a result of provider fraud convictions. DMAS managed care partner activity recovered and/or prevented an additional $10.6 million from similar program integrity activities.

DMAS Program Integrity Savings and Retractions (FY 2016)

MMIS Claims Edits $3,295,854
Provider Fraud $973,954
MCO Audit Activity $10,600,756
Provider Audits $18,981,164
Service Authorization $117,746,095
Recipient Audits and Fraud $4,913,340

PI Savings and Retractions Total = $156,511,163
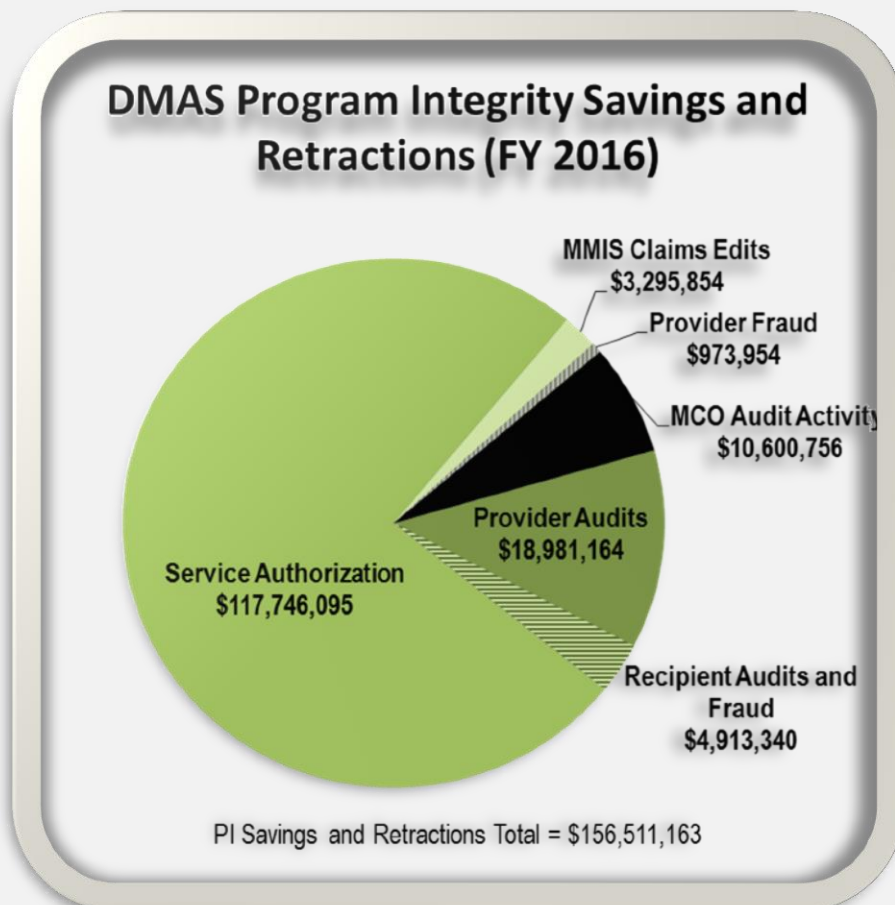
MISSION STATEMENT

The mission of the Program Integrity Division (PID) is to protect the Medicaid program from external abuse and fraudulent activities, recover inappropriate Medicaid payments, and support the integrity efforts of the various Medicaid programs by offering oversight and technical assistance.

PROGRAM INTEGRITY OVERVIEW

Prepayment

- **Prepayment** efforts prevent improper expenditures through front-end controls that ensure that claims are only authorized for appropriate and necessary services. These processes ensure that services rendered are medically necessary, that providers are eligible and enrolled in the Medicaid program and that claims are authorized according to DMAS policies on allowed services and national medical billing standards.

Payment Integrity

- **Payment Integrity** processes ensure DMAS identifies recipients who have other health coverage (Third-Party Liability) and that DMAS receives all of the rebates due from pharmacy manufacturers.

Data Analysis and Provider Selection

- **Data Analysis and Provider Selection** processes help DMAS to focus audits on areas where there is a high risk of overpayments. This ensures that program integrity resources are utilized in the most efficient and effective manner.

Post Payment

- **Post-payment** audits are conducted to identify claims paid improperly and recipients who are not eligible for the Medicaid program. By investigating referrals and reviewing medical record documentation, DMAS identifies improper expenditures and forwards potentially fraudulent cases on for criminal prosecution.

PREVENTING Improper Payments

Cost avoidance is the Department's first step in its PI efforts. Improper payment prevention reduces the need to "pay and chase" through post-payment audits. Two major components of prepayment program integrity are the service authorization process and the Medicaid Management Information System (MMIS) claims processing system.

SERVICE AUTHORIZATION

DMAS requires providers to obtain prior authorization of the medical necessity of certain services (referred to as service authorization) before a claim can be paid through MMIS. DMAS contracts with Keystone Peer Review Organization (KEPRO) which allows providers to submit requests by phone or via the internet. KEPRO medical staff review the information submitted by providers and determine if the service is medically necessary under DMAS policy. By denying services that were not medically necessary and reducing requested levels of service to appropriate levels, service authorization avoided costs of over $117 million in SFY 2016.

MMIS CLAIMS PROCESSING EDITS

DMAS has always subjected claims to rigorous prepayment scrutiny through its automated claims processing and review system called the Medicaid Management Information System (MMIS). This system contains hundreds of edits that reject inappropriate or improperly billed claims. These prepayment edits prevented $3,295,853.50 in improper payments in SFY 2016.

MONITORING PHARMACEUTICAL UTILIZATION

Improper usage of pharmaceuticals by recipients presents both program integrity and quality of care issues in the Medicaid program. Misuse and overuse of narcotics represent a major challenge nationally and in the Commonwealth and DMAS works to monitor and manage recipients to ensure proper utilization of narcotic medications. Within the DMAS fee-for-service program, the Recipient Monitoring Unit (RMU) evaluates recipient utilization for enrollment in a pharmaceutical management program. This program can involve assigning a recipient to a single prescribing physician and/or a single pharmacy to allow coordinated oversight of pharmaceutical usage. In addition to this program, DMAS' managed care organizations also conduct pharmacy management programs for their enrolled members. In SFY 2016, DMAS implemented the Patient Utilization Management Safety (PUMS) program with a goal of standardizing the triggers for enrolling a member in a management program.

RECIPIENT Eligibility

INVESTIGATIONS

DMAS conducts a wide variety of activities to ensure the accuracy and integrity of the Virginia Medicaid recipient enrollment processes conducted by local Departments of Social Services and others. Post-enrollment audits are conducted to identify recipients who were improperly enrolled in Medicaid, as well as to uncover improper payments made on behalf of ineligible recipients. DMAS also collaborates with the Virginia Department of Social Services, local commonwealth attorneys and a new eligibility contractor to address recipient fraud and abuse, as well as enrollment accuracy.

The Recipient Audit Unit (RAU) is responsible for the investigation of allegations of acts of fraud or abuse committed by recipients of the Medicaid, Family Access to Medical Insurance Security (FAMIS), and State & Local Hospital (SLH) programs. Typical eligibility issues uncovered in these reviews include deceit in the application process, illegal use/sharing of a Medicaid card, uncompensated transfer of property, excess resources or income, and fraudulent household composition. The unit also investigates drug diversion and performs joint investigations with various law enforcement entities (the Virginia State Police, the FBI, etc.), as well as the Social Security Administration, and other federal/state agencies.

RAU receives referrals from various sources, such as citizens, providers, and local Departments of Social Services. In SFY 2016, RAU investigated 1,930 referrals and uncovered a total of $3,044,977 in recoverable improper payments. In order to supplement the investigative work conducted by RAU staff, DMAS engaged a contractor, Myers and Stauffer, LC, in SFY 2016 to conduct 400 investigations of Medicaid recipients. These investigations identified an additional $ 1 million in recoverable improper payments. During SFY 2016, RAU in collaboration with local department of social services and local commonwealth attorneys, assisted in the prosecution and conviction of 33 individuals accused of health care fraud. These convictions resulted in court ordered restitution of $261,396.

Identifying Out-of-State Recipients

Public Assistance Reporting Information System (PARIS) is a computer matching system administered by the federal government that provides states with information about individuals who are enrolled in multiple State Medicaid programs. Beginning in July of 2013, the DMAS RAU established a group dedicated to investigating these cases to determine if the individuals were improperly enrolled in Virginia Medicaid. In SFY 2016, this unit investigated 683 cases and identified overpayments totaling $340,560. In addition to identifying overpayments, disenrolling these individuals prevents future improper payments. This is particularly true for recipients enrolled in managed care organizations, for which capitated monthly payments would be made regardless of whether the member used any services.

Eligibility Contractor

In order to supplement the excellent investigative work conducted by RAU staff, DMAS engaged a contractor in SFY 2016 to conduct 400 investigations of Medicaid recipients. These investigations identified a total of $1,466,928 in improper payments, of which $917,810 was submitted for administrative recovery.

New Eligibility System

DMAS is participating in federally-mandated Medicaid & CHIP Eligibility Review Pilots which consist of four rounds of reviews designed to test the new eligibility system and case worker actions as they relate to the new Modified Adjusted Gross Income (MAGI) eligibility determination methodology. This new system made income computations and tracking case information easier, resulting in more efficient case processing. Prior to implementation of the new eligibility online system, eligibility records were housed in different ways and different forms by localities. The new system has made case tracking and information access more uniform for eligibility reviews and case follow up. The system tracks and retains all necessary and relevant information for eligibility processing allowing agency follow-up to be conducted more efficiently. The system also identified eligibility areas requiring policy simplification or clarified policy guidance. Since the full implementation of a new eligibility processing the eligibility review pilots have shown a substantial decrease in inaccurate eligibility determinations. This decrease likely indicates that the new eligibility processing system is accomplishing its major objective—uniform and correct eligibility processing.

PROVIDER Audits

DMAS staff and contractors focus on provider audits. These audits examine a selection of claims paid during prior fiscal years to ensure the claims were paid in accordance with DMAS and Medicaid policy. In most cases these audits involve reviewing medical records to ensure the record exists, supports the claim as paid, and meets the requirements of DMAS policy and provider manuals. In addition, audits may examine the credentials of the servicing provider to ensure qualifications to provide the service that was paid. Contractors play an integral role in provider auditing, supplementing staff audits and providing knowledge and expertise in identifying audit targets and conducting reviews. As shown in the table below, during SFY 2016 provider audit activities, DMAS and its contractors identified about $19 million in overpayments to Medicaid providers.

	SFY 2016 Total Audits	SFY 2016 Overpayments
DMAS - Provider Review Unit	33	$3,586,037
DMAS - Mental Health	42	$574,556
DMAS - Hospital	75	$889,348
PID Audit Total	**107**	**$5,049,941**
Xerox - Pharmacy & DME (CY 2015)	50	$2,560,992
Health Management Systems - Hospital DRG	91	$5,784,824
Health Management Systems - Behavioral Health (6 month)	35	$631,613
Myers & Stauffer - Physicians & Waiver Services (CY 2015)	338	$4,953,794
Contractor Audit Total	**514**	**$13,931,223**
Total, PID and Contractor Audits	**621**	**$18,981,164**

Provider Audit Highlights

Behavioral Health Audits – PID has internal staff as well as a contractor whose efforts are focused on audits of behavioral health providers. Starting in December of 2013, DMAS began to contract with a Behavioral Health Services Administrator (BHSA) that acts as a fiscal agent for behavioral health services. PID staff collaborates with the BHSA to scrutinize behavioral health claims and conduct joint audits. The behavioral health auditing contract was reprocured in FY 2016 with a particular focus on identifying clinical areas that require additional oversight in an effort to educate the provider as well as improve the various behavioral health services. In addition, The RFP also clarified several programs that will affected by CMHRS audits including the Behavioral Health Services Administrator (BHSA), the Commonwealth Coordinated Care program, and the Governor's Access Plan. Particularly in relation to the BHSA and any other managed care agreements, the contractor will be expected to utilize fee-for-service data as well as encounter data to identify providers and claims for review.

Audit Standardization – DMAS underwent several efforts in FY 2016 to standardize audit practices across all audit contracts and staff audits. The audit methodology was adjusted in areas to align audits in terms of sample period length and percent of provider claims sampled. The mental health auditing contract was adjusted to increase the proportion of a provider's claims that are examined to be consistent with other DMAS audit contracts.

Recovery Audit Contractor (RAC) - Recovery Audit Contractor (RAC) is a term used to describe auditing firms who review medical claims for over- and under-payments and are paid a contingency fee based on actual recoveries resulting from their audits. . Under the Virginia RAC contract, DMAS pays a contingency fee of 9.3% of the actual amounts recovered as a result of RAC audit activities. As noted in the authorizing budget language, RAC recoveries are deposited into a special fund, out of which the contingency fee payments are made to the RAC. Since the initiation of the RAC contract in September 2012, the RAC has evaluated and analyzed DMAS historic data on processed claims to identify potential areas of audit. As of the end of SFY 2016, the RAC has identified and recovered $535,336.38 in payments from providers based on these audits.

Payment Suspension - Some DMAS audits uncover evidence that a provider has made an intentional misrepresentation in order to receive payment to which they are not entitled, otherwise known as fraud. Federal regulations (42 CFR § 455.23) direct states to suspend payments to providers in cases where there exists a "credible allegation of fraud". DMAS has worked with the MFCU to identify credible fraud allegations and implemented processes to block payment to those providers in the DMAS claims payment system. By implementing this process, DMAS is able to prevent additional payments from being made to fraudulent providers during the investigation and prosecution of their fraudulent activities. For FY 16 we have received 7 requests for Good Cause Exceptions, 7 requests for Suspension. There were 8 providers closed out of payment suspension due to convictions and 3 closed due to no merits of credible allegations of fraud.

Medicaid Fraud and Abuse Detection System - Fraud and abuse in Medicaid diverts funds that could otherwise be used for legitimate health care services. DMAS is committed to the continuous improvement of its PI tools to contain costs, reduce inaccurate or unauthorized claims and reimbursement, and better detect fraud and abuse. As a result, in July 2013, DMAS awarded the Medicaid Fraud and Abuse Detection (MFAD) system contract to Health Management Systems (HMS). Over the course of the contract, the MFAD has analyzed approximately $320 million dollars in claims to identify billing errors, claims processing errors, and misalignment of payment policies. In addition, the contractor supplied Provider Scorecarding, which assigns risk scores to a number of metrics that are associated with the provider ranking providers based on FWA vulnerabilities.

PROSECUTING Fraud

In addition to identifying improper payments, audits conducted by DMAS and its contractors may uncover evidence of potential fraud. Medicaid fraud is a criminal act that occurs when a Medicaid provider or recipient intentionally misrepresents themselves in order to receive an unauthorized benefit. Pursuant to federal law, Virginia's Medicaid Fraud Control Unit (MFCU) was established as a division of the Office of the Attorney General in 1982, and works closely with DMAS to investigate and prosecute suspected cases of Medicaid provider fraud. In addition to establishing restitution for past fraudulent activities, fraud convictions play an important role in program integrity more broadly, as convicted providers can be banned from Medicaid participation as well.

DMAS refers potential cases of fraud to the MFCU, provides program knowledge to aid in investigations, and, if required, testifies in cases. DMAS has an exceptional working relationship with the MFCU that continues to improve through constant communication and collaboration, including monthly meetings between staff of the two agencies, and the MFCU's participation in quarterly program integrity collaborative meetings with DMAS and its managed care partners. In SFY 2016, MFCU obtained convictions of 34 health care providers, a vast majority based on referrals from DMAS. Those cases resulted in a total of $973,953.80 in court-ordered restitution to the Virginia Medicaid program. In addition to working on criminal fraud cases, DMAS also aids MFCU civil prosecutions by reviewing records and testifying in national civil cases against pharmaceutical manufacturers. MFCU brought in an additional $35.1 million in recoveries from civil settlements.

The chart below represents DMAS referrals to MFCU over the last 10 fiscal years. In SFY 2016, DMAS made 100 fraud referrals, 7 of which were accepted by MFCU to be opened as full-scale fraud investigations. Ninety referrals from FY 2015 and 2016 are still pending, as MFCU has yet to fully vet those allegations.
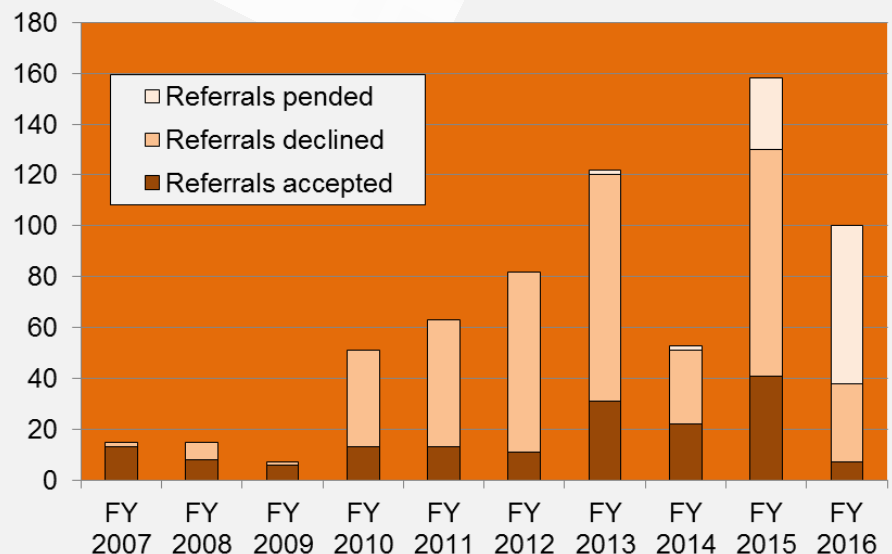
STAFF Training

Medicaid fraud, waste and abuse are areas that are constantly expanding and evolving. In order to identify and mitigate the impact of new and emerging schemes, DMAS staff members seek out opportunities to attend a wide variety of trainings on the latest topics in program integrity as well a present to other entities. One particularly valuable resource for this type of training is the Medicaid Integrity Institute, collaboration between the Centers for Medicaid and Medicare Services (CMS) and the Department of Justice to provide structured trainings at a facility in Columbia, SC. Program integrity staff members attended several of these trainings in SFY 2016, to include **Basic Techniques in Medicaid Fraud Detection Program, Managed Care Seminar, Program Integrity Fundamentals and Emerging Trends in Medicaid and Medicare.** PID staff also attended the National Association of Medicaid Program Integrity, the United Council on Welfare Fraud (UCOWF) Conference and the Public Assistance Information Reporting Systems (PARIS) Conference.

PID staff has also been active in conducting trainings. Examples follow:

Medicaid Fraud Control Unit Annual Training - staff provided an overview of the Program Integrity Division at DMAS with a focus on DMAS' Recipient Audit Unit and Provider Review Unit.

Recipient Audit Unit (RAU) Road Trip: RAU staff visited local Department of Social Services agencies to increase RAU communication, awareness, and presence amongst local workers. The visits were designed to inform local DSS eligibility and fraud workers of the function of the RAU and to review the RAU referral process. To date, RAU has visited over 20 LDSS agencies and communicated with over 275 local fraud and eligibility workers statewide. This novel approach to communication seeks to promote the Program Integrity goal of protecting the agency and the Medicaid program against fraud, waste and abuse and foster relationships between the two entities.

Virginia Benefit Programs Organization (BPRO) Fall Conference - The Recipient Audit Unit Manager facilitated a workshop at the fall 2015 BPRO conference held in Norfolk, VA. The workshop provided insight of the Recipient Audit Unit and Recipient Monitoring Units. The workshop shared unit functions (including the fraud referral process), highlighted current projects, and discussed means to share. This workshop also sought to foster and improve communications between DMAS Program Integrity and the local DSS agencies.

PROGRAM INTEGRITY
In Managed Care

The majority of Virginia Medicaid recipients are covered by managed care organizations (MCOs) that receive a contracted monthly rate for each enrolled member, and each MCO is responsible for paying providers directly for the medical services incurred by its members. Several projects currently underway will significantly expand the number of recipients covered under managed care arrangements by July 2017. MCOs are required by DMAS and CMS to have vigilant program integrity systems in place to prevent, detect and investigate allegations of fraud, waste and abuse. Through the first three quarters of SFY 2016, MCO program integrity activities avoided or recovered almost $898 million including $841 million in prevented payments for items such as non-covered services, ineligible recipients, and improper claims. Special Investigations Unit activity and vendor audits, which are similar to the activities conducted by PID staff and contractors, prevented or recovered $10.6 million in improper payments

DMAS continues to hold quarterly Managed Care Program Integrity Collaborative meetings which allow the MCOs and DMAS the opportunity to share information regarding PI issues. The meetings also provide a forum to identify problematic providers as well as trending fraudulent schemes. Successful approaches to mitigate and avoid abusive schemes are also discussed. Lastly, MFCU representatives attend these meetings to provide updates on fraud investigations and also to allow an opportunity to discuss potential fraud referrals.

Each year, DMAS conducts an audit of each MCO's compliance with the program integrity requirements under the MCO contract called the Program Integrity Compliance Audit (PICA.) The 2016 PICA review focused on audit plans that outline the planned program integrity activities of each MCO. DMAS reviewed each MCO's plan to ensure that they provided a complete overview of all efforts to prevent, detect and recover improper payments, and to verify that those efforts represented a coordinated approach to PI. DMAS also examined contractually-required reporting on investigations conducted by the MCOs to verify that the activities presented in the PICA represented real cases with substantive outcomes. Lastly, the review compared each MCO's activities with their projected volume of activities from the prior year to validate that the plans had adequately fulfilled their commitment to program integrity activities.
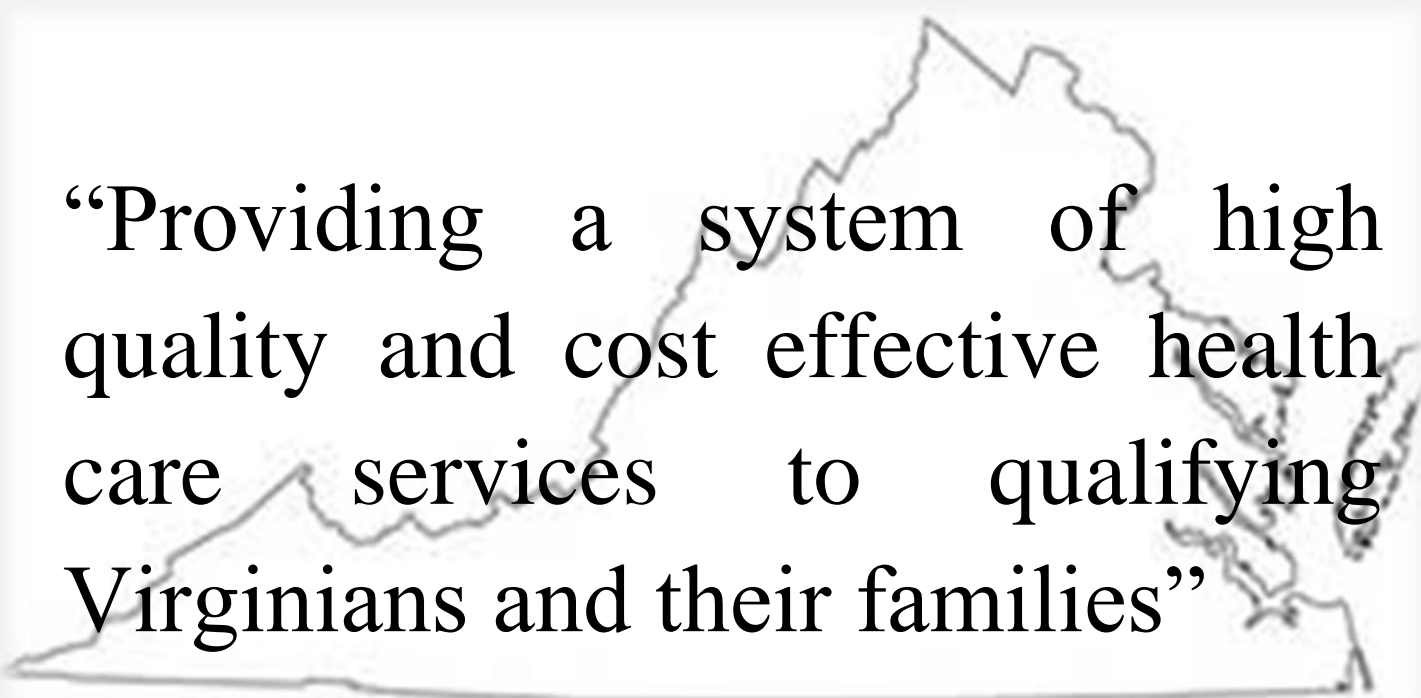
The success of the PICA project has led to the implementation of a similar review process for several other managed care and fiscal agent contracts, including the dental and transportation brokers, the consumer-directed fiscal agent and the behavioral health services administrator. A standard template is being used to assess each of these contractors on their performance of contractual requirements related to program integrity and provide feedback to the contractors on improvements to their programs that are needed.

CONCLUSION

The combined program integrity efforts of DMAS and its program integrity partners identified and/or prevented $156.5 million in improper expenditures in the Virginia Medicaid program in SFY 2016. The vast majority of these dollars ($121 million) were savings from prepayment activities, particularly the denial of medically unnecessary services through service authorization. Audits of providers and recipients uncovered another $22.3 million in improper payments during SFY 2016. Contract auditors play a large role in the DMAS PI process and DMAS continually evaluates these contracts to identify opportunities for enhancement through the development of new focus areas and deliverables.

DMAS has fostered a collaborative approach with its program integrity partners through monthly meetings with the Medicaid Fraud Control Unit as well as the quarterly Managed Care Program Integrity Collaborative. The collaborative has become a national model and has already helped to create an open and cooperative approach to PI in Virginia Medicaid across all payers. DMAS has worked actively over the past fiscal year to identify and mitigate fraud/abuse, resulting in criminal convictions of 33 Medicaid recipients and 34 Medicaid providers and over $1.2 million in court-ordered fines, penalties, and restitution to the Virginia Medicaid program in SFY 2016.

As we move forward, DMAS will continue to find ways to further ensure the integrity of the Medicaid program, and will remain vigilant in attempting to prevent fraud, waste and abuse.

"Providing a system of high quality and cost effective health care services to qualifying Virginians and their families"